Office use only: Last Name:_____Gender: Male/Female DOUBLE/SINGLE ROOM

OWI 2nd OFFENSE WEEKEND PROGRAM

REGISTRATION FORM

Online registration is available via www.assessmentiowa.com

PLEASE REMIT FORM VIA FAX/MAIL/EMAIL OR IN PERSON TO:

ASSESSMENT SERVICES INC.

6150 VILLAGE VIEW DR, SUITE 102

WEST DES MOINES, IA 50266

Ph: 515-327-7036 Fax: 875-4895 E-mail: astodden@assessmentiowa.com

REGISTRATION WILL NOT BE PROCESSED WITHOUT PAYMENT

Program Location: Microtel Inn & Suites 8711 Plum Drive, Urbandale, IA 50322

SECTION A-Registration/Dates

DATES OF PROGRAM 2019: (CIRCLE ONE)

JANUARY:	January 4-6 & 11-13, 2019
FEBRUARY:	February 1-3 & 8-10, 2019
MARCH:	March 1-3 & 8-10, 2019
APRIL:	April 5-7 & 12-14, 2019
MAY:	May 3-5 & 10-12, 2019
JUNE:	May 31-June 2 & June 7-9, 2019
JULY:	July 12-14 & July 19-21, 2019
AUGUST:	August 2-4 & 9-11, 2019
SEPTEMBER:	September 6-8 & 13-15, 2019
OCTOBER:	October 4-6 & 11-13, 2019
NOVEMBER:	November 1-3 & November 8-10, 2019
DECEMBER:	December 6-8 & 13-15, 2019

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SECTION B- Identifying

Name: _____

(Last) (First) (Middle)

Gender: (circle one) Male Female Age: ____ Date of Birth: _____/_____/_____

Social Security Number: _____DL Number (State):_____

Email address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home/Work Phone: _____Cell Phone: _____

Dietary Restrictions/Food Allergies (please specify): _____

Handicapped Accessible Room: Yes No

Section B - Legal

Pursuant to IAC 2.7(1), Your responses will remain confidential

County of Charge: _____ Criminal Case Number: _____

Are you on the Sex Offender Registry? Yes No

Have you ever been convicted of a sexual or violent crime? Yes No

If yes, please specify date/county/charge/conviction information: _____

Are you currently on probation? Yes No

If yes, name of probation officer/county of supervision: _____

Name of Attorney: _____

Section C - Emergency

Emergency Contact Information:

Name: _____ Phone: _____

Address: _____ Relationship: _____

Office use only: Last Name:_____Gender: Male/Female DOUBLE/SINGLE ROOM

Section D - Medical

Have you ever been diagnosed w/ a mental health issue? Yes No

Please Explain: _____

List all medications you are using: _____

Have you or are you currently having any suicidal/homicidal thoughts? Yes No

Please Explain: _____

Do you currently have any conditions we should know about? _____

_____

I understand that pursuant to the nature of this program, abstinence from all mood altering substances is mandatory. I understand that as a participant of this program, I will be continuously monitored for alcohol consumption to better simulate a controlled environment. I also understand that a breath test will be administered upon entering the program. ***Failure to provide a negative breath test will result in forfeiture of class fees and denial of entrance to the program***. I also understand that possession and consumption of illegal drugs is strictly prohibited. I have read and understand this policy.

Signature: _____ Date: _____

Indemnity/Release of Liability

I, _____, as a condition of participation in the Polk County 96 hour weekend program for OWI offenders, hereby release and hold harmless Polk County, its employees, officers and directors, Assessment Services Inc., its facility, employees, officers and directors, from any and all liability in connection with any claim of injury or otherwise as a result of participation in this program. My participation in the program is voluntary and I agree I am participating as such. This release includes but is not limited to claims related to wrongful death, personal injury, defamation, slander, libel, invasion of privacy or any other claim or cause of action, whether based upon statue or common law. I have read and understand this agreement.

Signature: _____ Date: _____

I verify that all statements on this form are true and accurate representations of my situation.

Signature: _____ Date: _____

ASI does not discriminate on the basis of race, color, sex, age, sexual orientation, creed, national origin, or disability. Any inquiries into this policy may be directed to ASI administration at (515-327-7036). However, to protect all participants and staff, ASI reserves the right to refuse enrollment subject to a history of violent or sexual offenses.

- I have selected my dates carefully and I hereby understand that once my registration is processed, all fees are non-refundable & non-transferrable.

Signature: _____ Date: _____

Office use only: Last Name:_____Gender: Male/Female DOUBLE/SINGLE ROOM

Section D- Payment

AMOUNT DUE: 650.00 SINGLE ROOM OPTION: 1200.00

Amount Enclosed: _____

Payment Type: (Circle) Cash Money Order Credit Card Paypal via (www.assessmentiowa.com)

Credit Card Information:

Name on Card: _____

Billing Address for Card: _____

Card Number: _____

Expiration Date: _____ Security Code: _____ Billing Zip Code: _____

- I hereby authorize ASI to debit my card for the aforementioned amount for the non-refundable registration fees.

Signature: _____ Date: _____

PLEASE NOTE: PERSONAL CHECKS WILL BE RETURNED UNPROCESSED. REGISTRATION FORMS SUBMITTED WITHOUT FEE WILL BE RETURNED UNPROCESSED. UPON REGISTRATION, A CONFIRMATION LETTER & PROGRAM INFORMATION GUIDE WILL BE PROVIDED.

ONCE PAYMENT IS PROCESSED, REGISTRATION FEE IS NON REFUNDABLE.